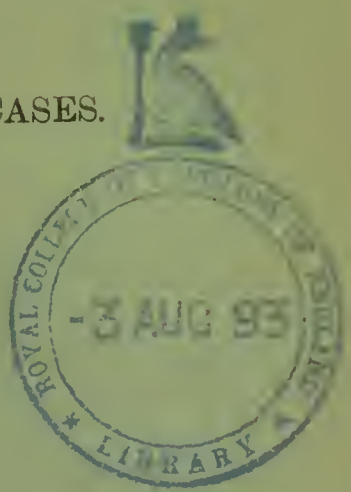
CLINICAL NOTES

ON

CHANCRE OF THE TONSIL,

WITH

ANALYSIS OF FIFTEEN CASES.



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CHANCRE OF THE TONSIL.

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THE subject of the extra-genital communication of syphilis, or syphilis as a non-venereal disease, is one which has excited a good deal of interest of late years, and a large amount of clinical material has accumulated illustrative of widely different modes of communication, some of which were presented by the present writer before this Society several years ago.[1] The purpose of the present paper is to call especial attention to one particular locality of the infecting sore which has not received the attention which its importance and frequency warrant, and to emphasize some points which will aid in the recognition of the initial lesion of syphilis on the tonsil.

In studying recently the subject of syphilis innocently acquired, I have been many times struck with the very great frequency with which reference is made by older writers to the disease being acquired in the throat, and a more careful investigation of the data shows that the entry of the poison was very commonly through the tonsils. Thus, in all the descriptions of sibbens, as it occurred in Scotland, in the radesyge of Norway, in the morbus Dithmarensis of Holland, and other epidemic and endemic affections now recognized to be syphilis, mention is made that the disease was communicated largely by eating and drinking, and that the lesions first appeared in the throat. For a long time these conditions were not recognized as syphilis, the reason being stated that there were no lesions on the genitals, and that the disease was not commonly communicated by venereal contact.

Chancres have been reported, of late years, upon almost every portion of the buccal cavity; but other than on the lips and tongue, the number have been very few as compared to those upon the tonsils. The reason for this is not difficult to discern. For the entrance of the syphilitic poison there must be a solution of con-

[1] Non-venereal Syphilis: Trans. N. Y. State Med. Assoc., 1886, p. 393.

tinuity, and such abrasions are comparatively rare within the cavity of the mouth, while the constant secretions and movements therein tend to prevent the absorption of the virus.

But with the tonsils it is far different. Here the numerous crypts, often large and gaping, and frequently the seat of inflammatory disease, form a ready nidus in which the syphilitic poison lodges, and from which it is not easily removed. Moreover, the movements of deglutition aid in forcing any syphilitic matter which may have been taken into the mouth into the follicles of the tonsils, which approach one another and often touch in the act of swallowing.

However it may occur, certain it is that chancre of the tonsil is a not very infrequent occurrence, although, as will be seen later, it very commonly escapes recognition because of the peculiar features presented by the sore in this locality. In a recent correspondence with Dr. Cæsar Boeck, of Norway, a high authority on syphilis, he stated to me that next to chancres in the genital region he had found the primary lesion of syphilis most common in the throat. The explanation of this great frequency of the sore in this location in Norway is probably found largely in the customs of the country, where the domestic life among the poor is very intimate, a whole family frequently eating with the same spoon, one after another; possibly, also, it is in part due to climatic reasons, leading to greater prevalence of inflammatory throat affections. From what I know and judge from literature and correspondence, I do not believe that the frequency of throat chancres there is due to bestial practices, such as we occasionally meet with in this country and elsewhere. Among my own cases, about to be mentioned, there were three which had this origin.

In examining the records of my private and public practice, I find more or less complete notes of over 2000 cases of syphilis, extending back over a period of more than twenty years. The larger number of these patients came under my care on account of skin lesions during various periods of the disease, generally after the primary sore had disappeared, and in some instances even very many years thereafter, and not more than one-third of the patients came on account of the local sore, or with its remains still present; it is, therefore, impossible to determine even approximately the number of instances of extra-genital chancre which occurred among them. For, while these latter would commonly attract attention, and were always noted when present, still in the large majority of

the cases of syphilis no record was made of the location of the primary lesion or source of infection; indeed, in very many cases these matters were not known positively either to the patient or myself. That there were many more cases of extra-genital infection than are to be mentioned, is beyond any question, for I do know positively that in a very considerable number of old cases it could never be determined how the disease was acquired, though in very many instances the proof was certain that it had not occurred by the venereal act.

Among these 2000 cases of syphilis, however, notes of extra-genital chancres occur in 111 instances, or over 5 per cent. of the whole. The following table gives the location of the sore and the sex of the patients:

TABLE EXHIBITING LOCATION OF EXTRA-GENITAL CHANCRES.

(Personal cases.)

Location.	Male.	Female.	Total.
Chancre of the lips	20	29	49
" " tonsil	8	7	15
" " finger	13	2	15
" " breast	...	7	7
" " tongue	3	2	5
" " cheek	5	...	5
" " eyelid	4	...	4
" " chin	2	1	3
" " hand	1	1	2
" " nose	1	...	1
" " ear	1	...	1
" " temple	...	1	1
" " neck	...	1	1
" " forearm	1	...	1
" " sacral region	1	...	1
	60	51	111

It will be seen here that chancre of the tonsil and chancre of the finger occur the same number of times, and come next in frequency to chancre of the lips; thus, there were 49 cases of chancre of the lips, and 15 of the tonsil, and 15 of the finger. Chancre of the tonsil thus formed almost 14 per cent. of all these cases of extra-genital chancre.

Of the cases of chancre of the tonsil, curiously enough, the sexes were almost evenly divided, there being 8 males and 7 females. The ages of the patients ranged from eleven to forty-six years; the youngest a boy of eleven, the son of one of the patients with

chancre of the lip; the oldest a gentleman, aged forty-six, who had not been exposed sexually and had surely no genital or extra-genital chancre elsewhere; he had very characteristic chancres on both tonsils, with distinct hardness, and a most beautiful macular syphilide of two weeks' duration, with great malaise, etc.; all of the symptoms yielded very promptly to mercury and chalk given every two hours. In this case, as has also occurred in a number of others, the physician bringing the case in consultation could not convince himself that the eruption was one of syphilis, because of his inability to find the chancre, and because of the absolute absence of venereal exposure.

The right tonsil would seem to be more liable to infection than the left; among these fifteen cases the right tonsil was affected alone in nine cases, the left alone in three cases, and both together in three cases.

Before calling particular attention to the clinical features to be observed in connection with chancre of the tonsil, I will give brief details of two cases, one male and one female, which are most perfect and typical, as full accounts of all the fifteen cases would occupy much time uselessly, and they will appear in detail in a work shortly to appear.[1]

Case I.—Mr. X. R., aged thirty-two, had what was supposed to be tonsillitis of the right side, six weeks previous to his visit, February 13, 1889. The swelling of the tonsil had not gone down, and a few weeks later a general eruption appeared covering much of the body.

When he first came for treatment the right tonsil was seen to be large, projecting half-way into the throat; the surface of it presented a superficial ulceration, the edges of which were quite prominent; the glands beneath the right jaw were enlarged, with a smaller amount of adenopathy on the other side. There was a maculo-papular eruption on the body which was fading.

In order to observe the tonsillar lesion more carefully, he was left two weeks without specific treatment, and he was cautioned in regard to the danger of infecting others. On the second visit, one week after the first, it was noted that the margin of the ulcer was more sharply defined, and that there was a very decided hardness to the touch; he was given a strong chlorate of potassa gargle and the non-specific treatment continued. The following week the characters of the chancre were even more sharply defined, and he was placed under active anti-syphilitic treatment, under which

[1] Syphilis Insontium: a Clinical and Historical Study of Syphilis Innocently Acquired. Awarded the Alvarenga Prize, by the College of Physicians, Philadelphia, 1891.

the tonsil gradually healed and the swelling lessened, and other phenomena passed away. A ringed syphilide appeared a month later, with abundant mucous patches.

No clue to the infection could be discovered; he drank beer rather freely, and thought that perhaps he had smoked another man's pipe. It should be added that he had no lesions on the penis or evidence of former venereal trouble.

Case II.—Mrs. X. S., aged thirty-two, who had been married ten years, and was the mother of four children, entered the Skin and Cancer Hospital, February 28, 1890, on account of a diffuse, large papular syphilide, tending to become pustular, on the scalp.

Her history was that about two months previous she had a severe sore throat, as her first symptom of ill health, which continued up to her admission to the hospital; this was accompanied with malaise and aching of bones. The eruption appeared first on the scalp, a few weeks after the throat became sore, and the hair began to fall rapidly, with the development of an eruption on the face, spreading downward over the body.

On admission both tonsils were found to be greatly enlarged, almost touching, and their surfaces seemed equally raw, with mucous patches abundant on the roof of the mouth and elsewhere in the buccal cavity.

It was not until March 21st, three weeks after admission, that under most active mercurial treatment, and many local applications, that the throat had improved sufficiently to admit of a positive diagnosis of chancre of the tonsil, although it had been supposed that the seat of infection was located there. The left tonsil had then subsided very considerably, and was soft, leaving the right one standing out prominently, and presenting a rather sharply defined ulcer and a very marked hardness to the touch.

No clue to the method of infection was obtained; her husband, from her description, probably had syphilis, but was never seen.

As the case was from the first suspected to be one of tonsillar chancre, the genital region was carefully and deeply examined, but no trace of an initial lesion could be found, although mucous patches were present, which had produced a soreness of the parts, and had appeared a month and more after the first development of the lesions in the throat.

We may now consider some of the features common to these and the other patients whose histories were very much like those which have been given. It may be stated that all the cases were seen and examined personally, many of them being under treatment almost from the beginning, and many of them continuing under observation for a long period thereafter. The longest period after the inception of the chancre at which any patient was seen was nine months. In ten of the cases the tonsillar chancre was observed at its height, in two cases the lesion had practically disappeared before coming under observation, and in two cases the process had retrograded greatly before being seen; but in all these cases, which were

most carefully studied, the history and train of symptoms, with the condition of the patient then present, were such as to make the diagnosis absolute.

In all the cases there had been no diagnosis of tonsillar chancre previously. Many of them had been treated as tonsillitis, one as diphtheria, one as grippe. It is fair, therefore, to suppose that the general profession, and even those engaged in throat practice, are not very familiar with the primary lesion of syphilis in this locality, and are not on the lookout for it. One of my most marked cases, in a young man, was sent to a throat clinic by one of my assistants before I saw the case, and was there treated for tonsillitis with iron and chlorate of potash. In one of my cases, in private practice, a lovely married lady, whose husband I saw, and who was certainly free from syphilis, had what was supposed to be tonsillitis, but which she herself recognized to be something different, owing to the stony hardness of the tonsil. In a month or thereabouts, while she had great malaise, supposed to be due to the tonsillitis, an eruption broke out, which was then called measles, and when the hair fell out, it was thought to follow that exanthem. When she came to me with a palmar and plantar syphilide, a month later, there was still the hardness of the tonsil, the greatly enlarged sub-maxillary glands of that side, and other manifestations of constitutional syphilis.

We may now briefly consider the symptoms commonly presented by these cases.

In most of my patients there has occurred, as the first symptom, a stinging pain in the tonsil to be affected, with a moderate pain on swallowing. The tonsil then swells pretty rapidly, so that at the height of the trouble it may project fully to the median line of the throat, and in some cases I have seen it enlarged vertically so as to reach above and behind the velum palati and below the ordinary visual line behind the tongue; in rare instances the enlargement is not very great.

The surface of the tonsil is always very red, but commonly, as in the primary lesion of syphilis of the penis and elsewhere, the ulceration is not a striking feature, indeed, in some instances there is very little loss of substance. But with care there can always be made out some erosion of surface, and the margin of this, as in chancre elsewhere, will be well defined and sharply cut, although seldom much elevated. The base of the sore will generally be

covered with a slight, whitish, sticky secretion, and does not strongly suggest ulceration. In some instances it is exceedingly difficult by simple inspection of the throat to determine exactly the true character of the lesion. But this is not to be wondered at, for in but few instances in chancres in other locations could the diagnosis be decided at once by a single inspection and without using the sense of touch.

And here comes the most important means of diagnosis, namely, the palpation of the tonsil, and this should never be neglected in doubtful cases. With the finger well guarded with carbolized vaseline, a thorough examination of both tonsils will generally throw much light on the character of the lesion. I find in my notes of these fifteen cases, that in ten of them the hardness of the tonsil was a marked and distinctive feature; in the other five instances the cases were seen some months after the inception of the disease, but in three of them there was still sufficient induration to contrast strongly with the other healthy tonsil.

This hardness of the tonsil is sometimes very striking, and I find recorded that two of my patients had themselves noticed the "stony hardness" of the organ. Epithelioma of the tonsil would, of course, simulate this hardness somewhat, but the excessive rarity of this, especially at the age of early middle life, when most of these tonsillar chancres occur, would exclude this to a great degree.

As in chancres elsewhere, there is commonly swelling of the nearest lymphatic glands when the local lesion has become at all pronounced. So in chancre of the tonsil we have those beneath the jaw of the affected side enlarged almost with the first appearance of the chancre. This enlargement of the sub-maxillary glands on the side of the tonsillar chancre was noted in every one of my cases, and in many had already been noticed by the patient. In a number of the cases post-cervical adenopathy of the same side had also occurred, and in some there was pretty general glandular enlargement elsewhere by the time they came under observation.

The occurrence of the eruption should, of course, establish the diagnosis with certainty, but in several of my cases this was not the fact, as the physicians who had seen the cases could not believe the eruption to be syphilis, because of the supposed absence of the chancre and the sure absence of venereal infection. As already remarked, the malaise, loss of hair, etc., is often explained as weak-

ness following the supposed tonsillitis, diphtheria, or grippe, which has affected the patient's throat.

It is to be remembered also that in certain cases the early skin symptoms are very light, and in some instances of syphilis I have known them to entirely escape the observation even of very intelligent patients; in a number of instances I have first demonstrated a macular rash to a patient and his physician; in the case already mentioned the early macular syphiloderm was supposed to be measles.

According to my observation the eruption in throat chancres has first developed about the head and face, extending slowly to the trunk and extremities, but I should not assert that this is always the case.

The syphilis arising from tonsillar chancre has, in my experience, generally run a pretty severe course, and in two instances in private practice, where it was acquired by young ladies of highest character and position, from kissing those to whom they were engaged to be married, the course of the disease was frightfully severe, wrecking their lives. The observation has been made by others that syphilis acquired extra-genitally is apt to be very severe, and I have found this to be true in regard to a large number of patients who had chancres in other extra-genital localities than the tonsil.

In regard to the modes by which the syphilitic poison reaches the tonsils in these cases it is often very difficult to determine the matter with certainty.

As already remarked, the earlier writers continually referred to the communication of the disease by eating and drinking, especially among the peasant communities of Europe, before the nature of the disease was known, and before the contagiousness of the mucous lesions of syphilis was recognized. And even in later years cases are continually being reported as occurring from eating and drinking after a syphilitic person. Very many cases are on record where chancre of the tonsil has occurred, often in aged persons, from the custom of tasting the nursing bottle which has been in the mouth of a syphilitic infant. Many cases are also reported from smoking pipes after syphilitic persons, although more commonly the infection then occurs on the lip. Many cases are also on record similar to those here mentioned, where the poison undoubtedly came from the mouth of others in kissing.

In my own cases there were three in young men where the lesion confessedly came from vile practices with their own sex, and one of these patients told me of a friend who had chancre of the lip from the same horrible source. In two of the cases, in young ladies, the contagion came presumably from kissing the gentlemen to whom they were engaged; one of these latter came later under my care with syphilis, he having also infected another lady with chancre on the lip, who was also my patient, and whom he married. In another estimable lady the tonsillar chancre came also from kissing frequently a cousin who had abundant mucous patches in the mouth, she also helping him to wash out the mouth. Of course, the poison may have found access otherwise than by kissing, for an instance is on record by Hardy, of Paris, where a trochc passed from mouth to mouth communicated syphilis. In two other cases, married women, the disease seemed to come from their husbands, through the mouth; and in another case, a girl, aged nineteen, singing in the opera, it was probably from kissing. In three male patients the infection seemed to come from a drinking-cup in one, and from either drinking or smoking a pipe in the other two. In the boy aged eleven, the poison probably came from his father, who had chancre of the lip and mucous patches in the mouth; but a female servant, from whom the father contracted the lip chancre, had also syphilis, and also came to me for treatment. In two instances no probable hypothesis could be made; one was the man aged forty-six, with chancre of each tonsil, and the other in a lovely lady, aged thirty-three, whose husband was free from syphilis, and the only possible supposition was that the infection came from a public drinking-cup.

The treatment of chancre of the tonsil does not differ essentially from that of syphilis in general. It is well to remember, however, the probable severity of the disease from this mode of infection, both to warn the patient against neglect of the case, and to carry out efficient treatment long enough to overcome the disease. Very great care should also be exercised by the patient against infecting others, for not only is there much virulent secretion from the local lesion on the tonsil, but mucous patches in the mouth are apt to be very abundant and severe in these cases. Mercury should be given with a free hand from the first, and the full course of anti-syphilitic treatment carried out for two years, at least, according to modern rules of therapeutics.

Locally, it is well to treat the sore, here as elsewhere, with occasional dusting with calomel and the black wash freely painted on; free gargling with saturated solution of chlorate of potash many times daily, helps greatly in removing the local trouble. Nitrate of silver in solution in moderate strength may sometimes be painted over the sore with advantage.

In closing this clinical study of chancre of the tonsil, which has already far exceeded the limits intended, I wish again to emphasize the fact that I believe the primary lesion of syphilis to occur very much more commonly in this location than is generally believed to be the fact. Of these fifteen cases twelve have been found in the ordinary run of my practice during the last ten years, that is since my attention has been especially called to the communication of syphilis by innocent means, and since I have devoted much study to the subject. I believe if we are on the lookout for these cases they will be more frequently found, and many otherwise inexplicable cases of syphilitic infection will be cleared up, and some innocent persons relieved of the suspicion of having contracted the disease by venereal acts.